

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-021211

Registration District No.

316

Primary Registration District No.

3059

Registrar's No.

200

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

FILED JUN 3 1963

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. St. Genevieve	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bonne Terre Mo.		Length of stay in 1b 1 Wk.	c. CITY OR TOWN St. Genevieve Mo. Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bonne Terre Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Rural Rt. Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Emile Middle Leo Last Griffard		4. DATE OF DEATH Month May Day 24 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/21/1889 9. AGE (last birthday) 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Mechanic	11. BIRTHPLACE (City and state or country) Ste Genevieve Mo. 12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Louis Griffard		13b. MOTHER'S MAIDEN NAME Jane Rudloff	14. NAME OF HUSBAND OR WIFE Stella Griffard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	17. INFORMANT Address Frances Arbuckle Ste. Genevieve, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) GENERALIZED ARTERIOSCLEROSIS			INTERVAL BETWEEN ONSET AND DEATH 2 wk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from 5-19-63 to 5-24-63 and last saw him alive on 5-24-63 Death occurred at 1:10 PM m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C. E. Carleton, M.D.		22b. ADDRESS Farmington, Mo	22c. DATE SIGNED 5-24-63
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 5/27/1963	23c. NAME OF CEMETERY OR CREMATORY Valley Spring Cemetery	23d. LOCATION (City, town, or county) (State) Ste Genevieve Mo.
24. FUNERAL DIRECTOR ADDRESS C.H. Cozean Farmington, Mo.		25. DATE RECD. BY LOCAL REG. May 24, 1963	26. REGISTRAR'S SIGNATURE E. Rudloff

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

1 0941

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JUN 19 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify, that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4084

P. O. Address Faragton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.